MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 28, 2004
9:32 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Mandated report on cardiothoracic surgeons' practice expense -- David Glass, Jill Bernstein

MR. GLASS: This is a related, but smaller, topic from the last one, so I don't think I'll be quite as short.

Here we're talking about cardiothoracic surgeons' practice expense for the clinical staff they bring to the hospitals. This was mandated in the MMA. We were asked to determine if the practice expense RVUs for thoracic and cardiac surgeons adequately take into account the cost of surgeons providing clinical staff in the hospital. It's due January 1st.

The background here is the RVUs for practice expense, and Nancy talked about this last month, in 1994 CMS was required to develop these resource-based expenses, as opposed to the cost-based. The BBA of '97 required a four-year phase-in, from '99 to '02. During that time, in 1999, CMS decided to exclude the expenses associated with the clinical staff physicians bring to the hospital. We're going to talk a little bit about that decision.

First of all, who are the clinical staff at the hospital, what are we talking about? These are people who may assist in the operating room. They can provide pre- and postoperative care. They could be physician's assistants, surgical technologists, nurse practitioners, CRNFAs and others. Some of those people are going to be eligible for separate payments and some are not, as we discussed last month.

Of course, some of these services can be done, such as surgical first assistant, could be done by physicians, including residents. And we're talking about here the non-physician practitioners or what's called the clinical staff.

CMS made this decision to exclude in 1999 the cost of these people for purposes of computing practice expenses. The CMS position at that time was that Medicare should not pay twice for the same service. Some of these people are paid separately, the physician assistants, nurse practitioners and clinical nurse specialists. They're paid separately for surgical first assisting but not for anything else. So if Medicare pays directly for these people, then why pay the surgeons to pay them also, which essentially is what it means to include them in the practice expense.

So they said, we shouldn't pay twice for those people. And if they're doing nursing, that duplicates the nursing that's in the payment to the hospital, or the facility. So if the hospital is responsible for it and being paid for it, why should we pay for it twice?

And if there somebody for the physician and we're talking about doing things like physician services such as pulling chest tubes or other postoperative sort of things, that's already been paid for in the physician work RVUs. So again, no reason for Medicare to pay for it twice.

But it also said it wasn't typical for most specialties. Said it only happened about 11 percent of the time. And finally they made the argument that it's inconsistent with law and regulation that all the Part B payments for hospitalized beneficiaries that are allowed are for services provided by physicians and specified first assistants, and no other charges are allowed. And this would be essentially allowing another charge. So those were the reasons CMS gave to exclude these costs from the practice expense.

HHS IG was asked to study this issue and they did a study in 2002 on cardiothoracic surgeons, clinical staff and hospitals. And they used a survey to come up with their findings. They found that 75 percent of cardiothoracic surgeons do bring clinical staff to the hospital. So although this may be uncommon for specialties in general it was, in fact, the norm for cardiothoracic surgeons.

But they did agree with CMS that this was already being paid for. They are either paying directly for them to the hospital or as part of physician work RVUs.

I have one other finding of interest is that 19 percent of the time the hospitals decided to reimburse the surgeons for the clinical staff they brought with them. They can do that only to the extent of the market price for the time of the staff, so it isn't a kickback or anything like that.

So they're limited in what they can reimburse but they're only, in fact, doing it 19 percent of the time and that's kind of an interesting existence proof that it can be done.

Also, our analysis then was that if separately billable staff or hospital reimburses, then Medicare wouldn't want to include it in the practice expense because the surgeons' cost is being offset. And it may not be offset 100 percent, it could be less, it could even be more. But the basic gross cost, so to speak, shouldn't be in the practice expense.

There are other possibilities that exist if they are not being reimbursed directly. For instance, bringing these clinical staff could increase the surgeons productivity. But in that case, the surgeon could offset the cost because his work RVUs, if you will, are being set to the average and if he can increase productively below that by use of clinical staff, presumably he's doing that in a way that essentially makes him some money and that he can therefore offset the cost that way.

If bringing clinical staff improves the quality, Medicare may want to recognize that. We went on a site visit to see who these clinical staff were, what they do, and that sort of thing. One of the things that the surgeons were bringing clinical staff to do was endoscopic vein harvesting for bypasses. They said that, in their view, this increased the quality of the operation and cut down on the infections and complications, allowed the patient to ambulate quicker. So they thought it improved quality. That maybe something that Medicare would want to recognize, the costs of bringing some clinical staff in the practice expense.

And finally, it could be that the physician just prefers to have these staff with them. That happened about 30 percent of the time, according to the IG survey, and it's not clear that Medicare would want to offset the cost.

So in sum, simply including all the cost of all clinical staff and the practice expense cost doesn't seem to be warranted.

However, of course, there are some complications. We've identified these two issues. One was an issue of equity really. Should the cost of separately billable staff in physicians' offices also be excluded from practice expense just as the ones who are brought to the hospital area? Some of the clinical staff in the office, such as physician assistants, nurse practitioners and clinical nurse specialists, can bill separately for services they provide in the physician's office. They get paid 85 percent of the fee schedule for some things and 100 percent for others if it's incident to.

And conceptually, you'd want to offset the cost of employing them by the revenue that they derive from separate payments. But that was not done when they completed the practice expense RVUs.

Another issue is kind of technical, and I'm sure you all memorized Nancy's explanations of how these PE RVUs were derived, but to review just briefly they used an AMA survey to come up with a clinical staff pool for each specialty. But there was no data on how much of the clinical staff pool were people in the office and how much were people that they brought to the hospital with them.

So this raises the question did the way that CMS removed the clinical staff result in appropriate RVUs for all the procedures. What happened was they had this big pool of expenses. And then they had the panels, which included physicians, come up with kind of clinical level staff for procedures, by procedure, estimates for each specialty. And then they allocated the dollars that were in this pool to each of those procedures. That's the point where CMS took out the clinical staff that were brought to the hospital, their expenses.

The problem is that left the pool that you originally started with still too big. And that too big pool was then reallocated among procedures.

The result of that is it drove up payment for office-based procedures and some of those procedures that were common with other specialties. So then they got averaged down in the RVU process.

So the question is it's not obvious and certainly not direct that this was an ideal way to do it. It's not clear that the results in good or bad RVUs or payments but it's so indirect that we think it may be something to be looked into.

The redistribution expected though was, as Nancy said, from some of these major procedures to office-based.

The conclusion for all of this is that the practice expense RVUs do not include the cost of clinical staff brought to the hospital. Congress asked us do they account for those costs.

The answer is yes because because the cost that should be accounted for are generally zero, so it's appropriate that they don't. But we do think that there may be better ways to remove those costs. To do that you need data to offset the separately payable staff in both the office and the hospital and to reestimate the pools and that sort of thing.

This could be made part of the next review of the practice expense RVUs that Nancy was talking about in some of the next steps we'd like to see. But probably you wouldn't want to re-examine all of that for just this reason.

The other question is could you address quality somehow, because we did say that the one time you might be interested in this is if the clinical staff were leading to increased quality. Again, we think quality could be addressed through a combined payment approach. We discussed some of that last time. It's conceptually attractive. It gets you to quality outcomes and improved care coordination.

We think it may be particularly appropriate for this cardiothoracic surgery question. We say that because it was used for the heart bypass demonstration. And then that demonstration, the global rate for all physician payments and hospital payments for two heart bypass DRGs, they put a global payment for each of those DRGs together. It turned out it saved money, led to lower costs in the hospitals, and the perception at least was of improved quality.

As noted in the paper, some hospitals actually shared the savings with the physicians from that demonstration. One of the ways they did it was one of them converted physician employees to hospital employees, which is very close to what we're talking about here. This may be a good test case for that.

So that's about it. We'd appreciate comments on the issue paper that you saw and anything else you would like to us to include in our letter report to Congress

MR. HACKBARTH: David, I know the review of the practice expense is a five-year cycle. When is the next one? Where are we in that cycle?

MR. GLASS: I have to ask Nancy. Nancy left. Kevin, do you know?

DR. HAYES: 2007.

DR. SCANLON: I think we have two different considerations that we need to focus on here. First of all, there's the issue of being consistent in how practice expense or relative values are being set. On that one, actually the first time that HCFA did that, back in the mid-90s, there was some controversy because in some ways the excluded certain expenses that they didn't think were necessarily appropriate. The message that appeared to come from the Congress was we want you to allocate what the expenses actually are and pay on the basis of what the expenses actually are, rather than some concept of what expenses should be.

And so HCFA then went back and redid this process, eliminated some of these what you might call edits that were throwing off expenses. But this edit, so to speak, was left in.

The big issue, in terms of whether it should have been left in under this system of we're going to allocate actual expenses, I think, is the question of is this typical for a cardiothoracic surgeon to bring a nurse to a hospital? And if it is, then the relative values are supposed to reflect typical services. Then this is something we should pay for through the practice expense. And if we want to avoid double payment, we need to adjust the hospital payment potentially, as well as the work component. If the work component was set up originally based upon the assumption that the thoracic surgeon is not assisted by a nurse, then it's inappropriate.

That's the kind of discussion we should be having, which is that we do this consistent with the rules and we look at these other things and we see whether or not we need to adjust them.

That's one path. The other path is to reopen this issue of Medicare should be concerned about efficient delivery of services and we should be thinking about, not just for thoracic surgeons, but potentially more probably the question of if we only validate what is out there in terms of the fees, is that the appropriate thing to do?

But that's a very much bigger question that this one. This one I think we've got to considered it in terms of the context. And having been back there and having to do the work on the report that you've got the diagram and practice expense in there, there was a clear message from Congress about what they wanted with respect to price expense relative values. I think that under that set of rules, in some ways, these should be recognized but we need to avoid double payment.

We also need to be conscious of this idea that there can be billing by other professions and we have to ask what do we want to do about that so we don't end up paying twice.

MR. HACKBARTH: Let me ask a question about that. You're saying Congress spoke clearly that they wanted the practice expense allocation to reflect what is, not somebody's notion of what should be. Then why are they asking us now what we think about this method? I assume that they're asking us because they want our opinion about whether this is the right way to do it, not whether CMS is adhering to their legislative mandate to do it the other way.

DR. SCANLON: I interpret the question that they are asking us whether or not they are adhering to the mandate. Because what has happened is that the thoracic surgeon --

MR. HACKBARTH: Is that anywhere in the mandate? What's the language? They asked us do we think this is an appropriate way to do it? Or do they ask us whether it adheres to Section -- could you read it to us, David?

The reason I ask that, though, is I think the answer to the question did they do it the way practice exists, it's a pretty obvious question. They don't need us to analyze that. Clearly, they did not do it in accordance with the way practice is currently organized.

And then CMS said we didn't do it that way for these four

reasons. I thought the issue that is in front of us is were CMS's reasons good ones.

David, what's the language?

DR. BERNSTEIN: Medicare Payment Advisory Commission, in this section referred to as the Commission, shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the Medicare Physician Fee Schedule under Section 1848 of the Social Security Act for physicians in the specialities of thoracic and cardiac surgery to determine whether such values adequately take into account the attendant costs that such physicians incur in providing clinical staff for patient care in hospitals.

DR. SCANLON: I interpret the idea of adequacy as opposed to appropriateness as saying are they doing what we asked them to do? Because basically over the years the thoracic surgeons have said this deserves to be included. This is our typical experience, which is the criterion for the fee schedule.

And CMS has come back, even after the HHS IG study, and said we're not going to include this. And so the Congress, in some respects, I think is asking us to be an arbitrator.

MR. HACKBARTH: On the face of the CMS reg, they are basically saying no, we are not adjusting the practice expense to reflect the actual costs. We are doing offsets to reflect the way we think it ought to be so it's compatible with the hospital payment system. So there's really no dispute there. The issue is is this inappropriate.

MR. GLASS: And they took out the cost of clinical staff brought to the hospital for everyone, for all surgeons, not just cardiothoracic surgeons but for everyone, just to clarify that. But yes, I guess we interpreted adequacy as should they be in there.

DR. REISCHAUER: What is adequacy? If the situation is going along the way it is and 75 percent of them are using them; right? Isn't that, by definition, adequate?

DR. SCANLON: I guess my sense here was the consistent application of the rules. And that this was an inconsistency. We got into these on a number of different occasions while we had to do work on the Part B drugs and the overpayments in the Part B drugs. And we linked that work to what was happening with respect to oncology payment and talked about the underpayment there, again because of an inconsistency in how practice expenses were being calculated.

From the perspective that we had at GAO, at least, was here's the set of instructions that came from the Congress and were they being faithfully implemented and pointing out when we felt that they weren't.

This was one of those cases where I think that they may not being faithfully implemented. It's an immediate easy reaction to say we don't want to pay twice for the service. But then the question is if we're going to try to avoid that, what adjusts should we make?

That's why I'm saying that to just deal with what the

Congress said, it would be think about the work component, think about the hospital payment. I have a whole other avenue to go down, which to me is an appropriateness sort of avenue, how should we pay for these services?

I think the idea that they took the clinical staff out for all other surgeons, there's a question of can other surgeons come in and make a case, saying this is the way we typically do this service. Because that's the distinction. If the IG study had shown that only 30 percent of thoracic surgeons used an assistant that they brought in, there would not be an issue here. Because then we would be consistent with what the rules had been for setting up the practice expense values.

MS. BURKE: I think Bill is exactly right and it's certainly my recollection of where we were. I want to talk for a moment in that vein, specifically about the text because I think there is this bigger question and I want to address specifically cardiothoracic and not the broader context, but specifically in this instance where there is historically a pattern of using services in this sense.

There is, on page three, this logic table. And one of the things that struck me was, as Bill suggests, I think we would all state affirmatively we have no interest in paying twice for the same thing in any instance. I think there are an interesting set of questions as to what is the pattern of practice? To what extent do we want to encourage separate billing for individuals? And to what extent are there individuals who do this who are not able to separately? There is an equity issue there.

But in this logic box, I was particularly stuck and somewhat uncomfortable with the third bullet, which suggests that essentially if it increases their productivity so they can go out and make more money, then that's enough answer, we don't have to pay for it. I'm not sure that's a solution or an answer that I would want to propose as being a reasonable one.

I think we ought to deal directly with the question of is it a legitimate expense? How do we sort out between the hospital side? Because what we have is a strange scenario where, in some cases, the hospital bears the cost, will pay the surgeon. In some cases, the individual can separately bill. There are also individuals who are not capable of billing. Does it make them any less useful? I think there's a quality issue over time that ought to be studied carefully about whether this is practice that is appropriate and, in fact, results in better quality.

I vaguely recall, Nancy and I both do, that there was a discussion around this. In fact, I believe the result was that, in fact, it was effective and it was a useful method of practice.

But I particularly am struck and am quite uncomfortable with saying that it ought to be just a question of well, they ought to be able to pay for it because it lets them bill for more of them because they have more time. I would sooner not have that as an answer to the question.

But I do think, to Bill's point, there is this complicated question of how do we separate out where it ought to be paid for?

If it ought to be paid for in both scenarios, in the sense that either the hospital or the physician, but it's a legitimate cost and we've got to figure out how to parse those out. I don't think we can simply say okay, if the hospital wants to pay for it fine, we'll pay for it there. If the doc wants to pay for it because they can bill separately, that's fine. But if they fall in this netherland of neither the hospital nor billing separately, does that make them illegitimate in terms of the cost of the care? And I don't think it does. But I think that's what this leads us do.

So I'm concerned about going down that track. But I particularly am struck by that particular point. I don't think it's something I would want to say.

MR. HACKBARTH: Would you address that?

MR. GLASS: The productivity one is kind of interesting because the question is if the work RVUs are set up at some point and they start using clinical staff to increase their productivity, and the work RVUs to stay constant, which in fact they did -- the work RVUs actually have gone up for some of these things -- then is it paying twice to pay them as part of practice expense for bringing in these people that are then going to increase their productivity without any change in --

MR. HACKBARTH: But in a basic sense, aren't all of the staff there to increase physician productivity? So the physician doesn't have to answer the phone, so the physician doesn't have to keep the books. They're all there to increase physician productivity.

MR. GLASS: I guess the question is the change.

MS. BURKE: But we pay for them. It's like a good circulating room nurse will increase productivity, but it doesn't mean we don't pay for her, that somehow she gets paid for because they are able to do more surgeries. That doesn't make sense. Either it is a legitimate cost or it's not. If it is, then we find a way to pay for it. You don't just say well, you figured it out because it means you can do 10 more whatevers. I don't think that's the answer to the --

DR. SCANLON: I think it points out some of the problems you have with administrative prices, that you almost need to be in a constant revision mode. We may talk about the need to revise the practice expense relative values through a peak, but you've also to keep the work side working and going at the same time. You also maybe should have some kind of link between the two. That if someone comes in and makes the case that we've reorganized the way this procedure is done and we're using more clinical staff within our offices, you ask the question okay, what does that imply for the work? And make both revisions at the same time.

MR. GLASS: And that's what struck us, that the work RVUs had not decreased. They, in fact, had stayed the same or gone up.

MR. DeBUSK: I think we should hear from Nick on that.

DR. WOLTER: I am reluctant to comment because our thoracic surgeons will read this someday.

I'll just be very practical and really not address the issue that Bill has raised. I think the traditional practice was the traditional practice. It wasn't necessarily any more valuable to the practice of thoracic surgery than if a pulmonologist did the same thing or a general surgeon did the same thing. So from a practical standpoint, the result of valuing this and paying for it in a different way, to me, is not consistent with how the practice of medicine is done in other places.

But I think it does point up the fact that for physicians who do their work primarily in the hospital, these artificial separate payment systems are problematic and they get us into these quagmire conversations. I know the thoracic surgeons have felt that their payment on the outpatient side hasn't been valued adequately, and I'm sure that's one of the reasons this issue is on the table.

I don't know where that takes us down the road, but that is why the Part A/Part B thing is more problematic. And especially as we get into looking at how quality is driven in the physician world, where they work primarily in the hospital, continuing to do the silos separately in terms of those quality payment adjustments, we're going to have more issues like this eventually.

MR. HACKBARTH: Other comments? Answers?

DR. MILLER: Unfortunately, I have to summarize, I think, what has just happened here and I'm struggling with that a little bit. Do you want to?

MR. HACKBARTH: No. He was whispering the right answer to me.

DR. MILLER: I'm not at all sure of that.

I have to admit, I'm a little unclear on the difference of the mission of adhering to the law versus what the right thing is. I understand the distinction, but what our mission is, even given the mandate, we may speak to the mandate and also speak to the right thing.

I think, in some ways, Nick is saying Medicare shouldn't be in a position -- no payer should be in the position of litigating these things item by item. The way this litigation should work is on the floor, in the hospital, with the clinician saying I need this person because it makes me more productive, higher quality, whatever the case may be. And we should be able to work that out among ourselves, hospital and physician, in that conversation. So I get that and I think that's one point.

To the more narrow point of this, I think the bridge here, while you may not like the bridge or may not agree with it, I think the bridge is that you could say that the decision was we're pulling this out and one could reach the conclusion that it's potentially appropriate because it's been paid for elsewhere, either through other people who bill separately or through the hospital payment.

And so there's a narrow question of did you get the practice expense right for this thoracic surgery? And the answer might be look, if that's all you're looking at, the answer is no. And I

think we do the knowledge that those costs were pulled out in the paper.

The broader decision is but there was some thought that this was taken, the slack if you will, was taken up, probably not completely or appropriately or all the rest of it, elsewhere. And so that this was a reasonable decision.

And I'll stop talking with just one other thing. The one other thought I wanted to ask you guys is when we say at the end of the paper -- and that's what I was going through at the end, to try and figure out how big of a difference we actually had here -- we're saying at the legislative time that one could revisit work expense RVUs, we have this sentence, at that time you could take into account more generally the effect of clinical staff brought to the hospital.

In that instance, is it possible that the solution that is contemplated is yes, you could make an upward adjustment to the payment at that point in time? And you could have as a rider along with that language, but if you're going to do it that way you have to take it out of everything else to do it right.

I'm trying to figure out whether there's really a big disagreement here or whether what we're saying in the conclusion is when that's revisited, that could be revisited either way.

MS. BURKE: Mark, can I just ask you question following on to that suggestion with the following scenario? If that, in fact, is the direction we take, then the scenario today is the hospital can pay for the services, essentially their staff. Or they can choose to pay for the staff that the physician brings with them. Or the individuals who bill separately can bill separately.

So we're either telling the hospital to do it or people that bill separately. But if the physician employs those people, who are not able to or that we don't want to particularly encourage separate billing for staff that are an integral part of their clinical staff when they come to the hospital, we're essentially saying there is no option. The only option is the hospital eats the cost; correct?

MR. GLASS: A simple kind of compromise view of this would be is you take what the reported clinical staff brought to the hospital costs are and you subtract from that any separately payable. Right? Because you could figured that out. CMS could figure that out.

MS. BURKE: Separately payable to whom?

MR. GLASS: Staff that physicians bring who receive separate payment from Medicare.

MS. BURKE: And if they can't bill independently?

MR. GLASS: No, you can let them go ahead and do that, but you could take the sum of all of that happening and subtract. You can identify which procedures we're talking about. You can take the sum of all that happening and subtract from the amount the physicians are claiming as practice expense.

DR. MILLER: But the other logical solution is you put it all in and tell them that they can bill separately. That's why

CMS felt themselves in a bit of a box, notwithstanding all of the data problems and the rest of that, and just how complicated it was to estimate this, because they were saying there were these other revenue streams going on. And our view is well, I'm not sure they're not be compensated.

MS. BURKE: I guess the problem is in individual circumstances and whether or not it is considered part of the base or not, whether you make the subtraction. If, in fact, someone bill's independently, then clearly it ought not be paid to the physician as part of their costs. No question.

If the hospital incurs that cost, it ought not to be billed separately. But in the case where the physician bears those costs, they are not independently billed for by the individuals that work for the physician. then essentially the only scenario is that the physician, because it's not in the base -- I mean, essentially if you pulled it out of that practice cost, it is not in their reimbursement. So in that case, they simply bear the cost; correct?

DR. MILLER: Except that when you construct this it's going to be an average payment across the specialty that will reflect a lot different outcomes.

MS. BURKE: If it's an average payment where it does not exist, where it's not part of that calculation, if the average for the physician is calculated minus those amounts that you assume are going to be separately billed, then in no case will it be represented in their payment because your presumption is it's being billed separately. So it is no longer part of the average. Or am I missing what you're suggesting? It's out of the calculus.

MR. GLASS: If the practice expense pool you start with includes the expense of everyone works for the physician, including the people who get paid separately, then it would seem reasonable to at least subtract that out, the separate payments.

MS. BURKE: Absolutely.

MR. GLASS: That would be the compromise position on this is you say well, I think you may still want to look at -- you don't even have to do that.

If you have this entire big practice expense pool that included all the people who work for the physicians and then subtract out all the separate payments made to those people who work for the physician, both the ones he brings to the hospital and the ones who work in his office, I guess you could conceivably do that to get rid of some of the double payment question.

MR. HACKBARTH: Do we know anything about the proportions here? So of all of the people that thoracic surgeons bring to the hospital do we know what proportion of those are, in fact, people who bill separately, staff who are able to bill separately for Medicare?

MR. GLASS: No, I think the Society of Thoracic Surgeons did come up with a figure of how much they received the year this was done, but I think it was like $19 million, I think.

MR. HACKBARTH: $19 million relative to --

MR. GLASS: $19 million relative to 45 or something.

MS. DePARLE: Didn't the IG report cover this?

MR. GLASS: They may have. I'm not sure that we have that.

MR. HACKBARTH: Sheila is saying that that's a critical question. If you say we're going to forget about paying twice for people that the hospital could have provided but didn't, and we're going to recognize those as still legitimate physician expenses, and the only deduction we're going to make is for people who bill separately, then a critical variable is how much of this expense that currently is not counted actually is billed for separately? And it may take a big number and reduce it way down. I don't have any firsthand knowledge but I would guess that a lot of these people are separately billable physician assistants.

DR. MILLER: David, wasn't that the figure that they weren't able to break out?

MR. GLASS: In the practice pool they started with, they couldn't break out between clinical staff brought to the hospital and clinical staff used in the office to begin with. That's the first problem.

DR. STOWERS: It just seems to me that this really isn't something we should really be involved in at all. This is really between the hospital and that physician that's bringing in a worker that the hospital really should have provided in the first place. So if we're only going to pay for it one time, then they can work it out, whether the hospital provides that person or the physician does and the physician gets reimbursed for it at fair market value so there's no incentive thing created.

MS. BURKE: But the question is is it a part of what is calculated as the physician's reimbursement? It is an issue for us if we are either including or excluding it in the practice expense.

So to that extent, it is an issue for us because the question we ask is are they being adequately reimbursed.

DR. STOWERS: But is that our job, to reimburse them when the hospital is already being paid for that? Or is it the hospital's job to reimburse them for that? And I'm saying it's really the hospital's job to reimburse them for that because we are already paying the hospital for that type of --

MR. HACKBARTH: What I hear Bill saying is that the history of this is that Congress said no, we want them to have that counted in the practice expense. We don't want them to have to go chase the hospital and negotiate the hospital.

DR. SCANLON: I don't think Congress was as specific as that. Congress said we want to pay for what is. In this instance, Ray, I think that what the thoracic surgeons argued to us at GAO was that these people were -- they did deal with the issue of the surgeons' productivity, that they were substitutes for the surgeons' time. And the only reason that they regarded them as substitutes for the surgeons' time was because they were in partnership with the surgeon, as opposed to be an employee of

the hospital.

So that this nurse was with this surgeon and the surgeon knew that they could rely upon this nurse and wanted that nurse to be their employee. So it's very parallel to what happens in an office, in terms of hiring clinical staff and using clinical staff. The complicating factor is that it's happening in the hospital.

MS. BURKE: To your point if, in fact, if we do presume the hospital bears the costs, which I understand, then they shouldn't be allowed to be able to bill. Then it's a zero-sum game. Then it's the hospital's problem and no one should they be able to bill. The only difference here is there are people who can bill and people who can't. So if our decision is, as you suggest, that this ought to be a hospital/physician relationship, then the hospital bears the costs. In those circumstances should anybody be able to independently bill for that activity? That would be consistent.

DR. STOWERS: And essentially what I'm saying is that we're paying for this service. If the hospital negotiates with the physician to allow that physician to use theirs to increase efficiency and whatever, that there's something worked out between the hospital and the physician to reimburse the physician for them being the one that is supplying that and we're out of it at that point. That's all I'm trying to say.

MS. BURKE: Which is fine, but under those circumstances we should prohibit people from billing because right now people can bill independently.

DR. STOWERS: I understand.

MS. BURKE: So we should stop the billing as well.

DR. WOLTER: I don't know if what I see is representative across the world but my sense is where billing occurs it's usually sustained in the operating room. My sense is those are not the nurses who do rounds for the physician and write in the notes and sometimes do the dictations. I don't think there's a billing mechanism for that.

I think what's primarily being requested here is the latter activity, since the former activity, assisting in the operating room, does have the opportunity for billing.

MR. GLASS: Depending on who it is. Is this a surgical tech?

DR. WOLTER: My point is the surgical tech, there's some billing, that's probably not the activity for which some kind of recognition is now being requested. In my observation of cardiothoracic surgeons, they did have a history of bringing a nurse into the hospital, helping them with rounds, helping them go over medications at discharge time and that sort of thing.

Personally, I think the only argument for going ahead and recognizing that would be if there was some typical practice language at a certain point in time that we would want to grandfather that activity in, because I think that many people could make the argument that that might be valuable to their practice. But in fact, in all other cases, that is an

arrangement physicians work out with hospital staff, in terms of how medication, discharges and medications and that sort of thing are done. And that's why I think this is complicated.

MR. HACKBARTH: Nick, let me ask you a question. Isn't the surgeon getting a global fee that covers not just the time in the OR cutting, but also the rounds?

So if you're a first assistant, say a PA, working with out of the practice of cardiothoracic surgeon, assisting at surgery, and then doing post-op rounds and whatnot, and you're getting a first assistant's fee, billing separately for that for the practice, doesn't that cover also post-op rounds and whatnot?

DR. WOLTER: My understanding is there is a mechanism to do some billing for non-physician assisting in the operating room.

MR. HACKBARTH: For just the OR time?

DR. WOLTER: For just the OR time. And from what I've observed, that is a different individual than the nurse or assistant who accompanies the physician and works with the patient out on the floors or in the ICU. That's what I've observed.

DR. SCANLON: Glenn, on the assistants at surgery, that fee has just been set at 13 percent for these personnel of the global fee without an empirical basis to say that this is what it should be. Also, I think the more widespread perception is that it's only for operating room time. Because when a surgeon is the assistant, a physician is the assistant, then it's more clearly defined as only operating room time.

DR. REISCHAUER: Just a factual question here. 75 percent of the time the surgeon brings somebody with them. 19 percent of the time the hospital reimburses a physician for this activity. 81 percent of the time of the 75 percent, I suppose, that doesn't take place. Of that 81 percent, what fraction are separately billable folks and what fraction are actual employees of the doc?

And if there are these two avenues you wonder what is the economic logic ever of having your individual, as opposed to the separately billable person, involved in this? I mean one that you have an ongoing relationship with.

MR. GLASS: It seems to me that there are people that they feel -- that have been working with them, they're training to work with them.

DR. REISCHAUER: But a physician's assistant could be somebody --

MR. GLASS: They also use surgical technologists, for example. The place we visited, one of the people is a surgical technologist.

DR. REISCHAUER: Do you know what the percentage split is on that?

MR. GLASS: We don't know the percentage, no. But the surgeon thought it was important enough to have that particular individual that that's who he brought.

MR. HACKBARTH: I feel like we're spinning our wheels a little bit. Personally, I'd like to learn more about the history

that Bill described so we understand exactly the question that we're being asked by the Congress. I had a different notion in my head and I may have been wrong.

I'd like, if at all possible, to see if we could at least get some idea of the magnitude of some of these numbers that Sheila and Bob have been referring to. It gives us at least some sense of proportion of what we're talking about.

So let us do little homework on those issues and come back, hopefully in a way that will allow us to get efficiently to a conclusion. Jay, and then Pete, and then we'll move on.

DR. CROSSON: I understand the mandate is about cardiovascular surgeons bringing people to the hospital to help. But it sounds like they're not the only ones who do this. Other surgeons do. They may be the ones that do it most frequently, but others do this also.

So it strikes me that if we end up with a recommendation that is narrow, just to cardiovascular surgeons, which is what the mandate is, the very next question then would likely be what about the other surgeons who do this?

As we work our way through to a recommendation, I think we ought to acknowledge that and make a conscious decision which of the two things we want to do and what the implication is of just doing it narrowly.

MR. HACKBARTH: I think that's a good point. There certainly are other types of surgeons, orthopedic surgeons for example, where I think this is relatively common. What I heard David say, though, or maybe it was Bill, said that this is the one where it's very common as opposed to something that happens occasionally. But we can track down those. And that ought to be something we address specifically in the report.

MR. DeBUSK: We've sort of gone in circles here about how this thing happens. But if at present the physician is being paid, which of course he is, and he has a nurse practitioner or a PA who is billing separate, then the question comes down what about the physician who is coming to the hospital to do the surgery, that first assistant is there but there's an additional person who is helping with that, taking care of that patient to provide better patient quality? Then it looks to me like we're in a scenario where we're going to take and add another level of payment, maybe in addition to the doctor's fee, to cover that nurse. Isn't that about where we're at? That's the question?

MR. HACKBARTH: That's the question at hand, is whether that additional expense ought to be includable in the physician practice expense for cardiothoracic surgeons. CMS is concern is that we're double paying for that service, so they didn't want to take into account all of these. Am I missing your point, Pete?

MR. DeBUSK: I'm just looking. It's all about that third person and is that third person qualified or should they be paid? Are we already paying for that? And of course, we're talking about the hospital reimburses partially for this.

It looks to me like there should be the option well, if the doctor's going to bring this then the hospital should be mandated

to pay for that if you're going to get it fair and equal and what have you here to cover the surgeons' cost.

If what we're doing already, doing something in addition, moving some money around, it doesn't look to me like it should be that complicated. Just identify that person and pay them.

MR. HACKBARTH: In Nick's world, it isn't all this complicated. If they're dealing with a prepaid system, they've got a pool of dollars and they can work it out relatively easily, I imagine. But when we've got all of our separate payment silos and rules, it's hellishly complicated I'm afraid.

MR. DeBUSK: I don't think those silos, I don't think they are necessarily wanting these silos to go away under the present structure or they wouldn't be bringing this up.

MR. HACKBARTH: We are done for now.

I'm really looking forward to our next discussion of this. I just can't wait.

The last item is the mandated report asking about eliminating physician referrals to physical therapy.